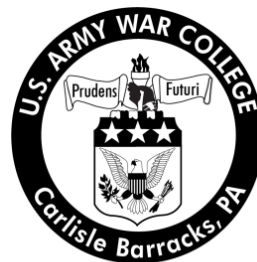


Strategy Research Project

Unified Medical Command and Control in the Department Of Defense

by

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United States Army



United States Army War College
Class of 2012

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USAWC STRATEGY RESEARCH PROJECT

**UNIFIED MEDICAL COMMAND AND CONTROL IN THE DEPARTMENT OF
DEFENSE**

by

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ABSTRACT

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Delivering health care to service members, retirees and their family members is essential to the morale and readiness of the Armed Forces. Indeed, it is viewed as a contract with service members to keep them healthy and treat them when they are sick or wounded. It is becoming increasingly more difficult for Defense Health Program (DHP) to deliver on this contract, however. At an estimated \$57 billion last year, the contract is not cheap. Defense spending, in general, faces tremendous scrutiny and the Military Health System (MHS) constitutes a significant portion of defense spending. This makes military health care a target for budget cuts. The MHS must rethink how supports the force, in both the operational and institutional medicine arenas. All options must be on the table and the toughest options may require radical changes to do the most good. Any solution must deliver cost savings, which means that some protected aspects of the MHS will need to change.

MILITARY HEALTH SYSTEM (MHS) JOINT MEDICAL COMMAND AND CONTROL

Military Health Systems Governance Today

The Military Health System (MHS) or the DHP is complicated, expensive and is quite often referred to as an “Enterprise”. Webster defines an enterprise as “any purposeful or systematic activity with common goals and ideals”¹. The MHS is a certainly purposeful, systematic, and possesses common goals; therefore it is an enterprise. As with any other enterprise the MHS faces challenges in budgeting, recapitalization, personnel training, recruitment, and leadership. At the same time the MHS has its own peculiar challenges not usually encountered by other corporations. One of those challenges is the fact that the US military has clusters of beneficiaries in the form of active duty, retirees and eligible family members—both CONUS and OCONUS—representing multiple, or all, services and all requiring similar access to healthcare. These clusters are treated and serviced by the military healthcare system as Multi-Service Markets (MSMs). Multi-Service Markets as a method to consolidate medical capabilities and facilities were implemented in several places, to include the National Capital region in September of 2004. The then Commanding General of the Walter Reed Army Medical Center, MG Farmer, described MSM implementation in the NCR as, the office to help link all the tri-service facilities, both big and little, in the national capital area together to form an integrated health delivery network under one health plan, with the intent to provide more seamless care for beneficiaries².

This is the institutional medical care aspect of the MHS which has engaged in numerous efforts over the past 25 years to better manage the delivery and coordination

of health services in the “healthcare market”. In addition, when more than one Military Department maintains a medical treatment facility, MSM becomes a joint enterprise. Even though the MSM concept has emerged as a potential way to effectively deliver patient care in this environment³, it is still a challenge to sustain roles and responsibilities of the military departments as their service equities become more of a priority.

The other aspect of the MHS is operational medicine, which provides healthcare to the joint force, plans, prepares and trains deployable medical personnel to operate in tactical environments. Operational medicine delivery is less costly than institutional care but definitely as important. Indeed, operational medicine is why the services medical departments exist.

Governing the MHS entails unique challenges and responsibilities. There aren’t many systems that are as comprehensive and complicated in its missions or beneficiary population, nor do they have the diverse populations to service.

Comprehensive healthcare is due to service members and their families from the day a service member is accessioned into the military. This includes preventive care, education, treatment for injuries and illness, and convalescence⁴. Additionally, the MHS provides care to retired service members throughout their lives after active service. Simply put, all aspects of care, across the health care continuum, must be accessible to beneficiaries, trained for, and maintained at the highest quality level.

In addition to operating its own hospitals and clinics, the MHS Enterprise oversees contractor operated health maintenance organizations, preferred provider organizations, and fee for services provider based health care through TRICARE.

TRICARE is an effective business process of reimbursable care that the Defense Health Program (DHP) uses to address issues such as provider-patient relationships.⁵

TRICARE was established-originally as CHAMPUS-in 1966 and expanded into its current form as TRICARE in 1993⁶. Retirees and family members of active duty and retired service members are entitled to care in the MHS on a space-available basis. CHAMPUS and TRICARE were established to provide a broader base of provider services and to ensure that care was available in areas that were not served by MHS facilities.

Beneficiaries are spread across the globe which makes the MHS an international enterprise. Service members and their family members are assigned from Europe to the Far East, so governing the MHS is a challenge not limited to the contiguous United States. Overseas MHS managers must monitor foreign health care provider organizations that serve military beneficiaries through TRICARE. Providers have to be flexible and informed to stay abreast of an ever changing environment, leadership must continue to seek opportunities to better manage while never compromising the quality of care they are required to provide.

Another unique challenge for the MHS is that the providers are part of the beneficiary population. This challenge is manifested even more in the operational medical force⁷. Leadership is challenged to strike a balance between military readiness and the access to care. Tracking medical personnel across the force creates a natural tension in their ability to execute training and readiness requirements while continuing to serve the joint force population. Ten years of continuous war has taken its toll on a very small population of providers. Physicians, physician assistants, nurses, and medics

have typically deployed and continue to deploy at least the same rates and in some cases even higher rates than their counterparts in other military occupational specialties⁸.

Military personnel are highly transient, which is a barrier to building strong provider/patient relationships. This fundamental difference between military and civilian healthcare populations can impede more effective care delivery. Physicians and treatment teams are constantly “starting over” with their patients instead of having a historical perspective on their patients that providers enjoy in other environments⁹. The military’s 20 year retirement opportunity results in an ever-growing retiree population, which is further complicated by the fact that people live longer and remain in the Defense healthcare system even longer. The retiree beneficiary population’s healthcare needs increase exponentially as they age.

The MHS must provide healthcare from institutional medical facilities to the theater of operations. It must also operate a highly complex logistics enterprise. The American people demand the highest standards of care for their troops regardless of where in the world they may be. Access to care, ensuring standards of care, and ensuring needed supplies and equipment are available, whether in the Washington DC suburbs or Bagram Airbase presents unique challenges to managing an already an already tough governance model in a seriously complicated enterprise¹⁰.

Governing DoD health is more complicated because the Army, Navy and Air Force health systems pursue and execute programs to support their own populations, sometimes without regard to the capabilities and constraints of the other services’ health systems. This approach creates redundancies and does not maximize the

potential leverage to be gained through sheer velocity¹¹. The MHS as a whole currently has no singular corporate process for making strategic decisions across all the services and all capability areas. Each service has separate legal responsibilities to take care of their own populations under Title X US Code responsibilities¹².

Initiatives have been proposed to develop mutual and shared capabilities among the three services. These attempts to design an enterprise that performs jointly have been most successful at the local military treatment facilities level and less successful at higher levels in the services and the DoD. True, needed, change must come in higher MHS and DoD command and control arenas in order to be enduring.

The current joint initiatives in healthcare delivery whether top-down directed or bottom-up implemented, leave much on the table. Various pilot projects have sought to better integrate the combined medical capabilities of the Army, Navy and Air Force to optimize the direct care delivery systems, and ensure that the available capacity of these systems are used before health care is referred to the private sector or TRICARE¹³.

An underlying and problematic assumption is that, absent a formal process to manage these independent medical systems, there will be unnecessary and inefficient duplication of services and/or missed opportunities for greater collaboration and sharing that result in sub-optimization of medical skills (for both graduate medical education and ongoing maintenance of provider currency)¹⁴. It is also assumed that failing to create formal management structures (mission, staff, budget, outputs) results in increased costs due to less than full utilization of MHS resources to optimize healthcare delivery in a specified geographic area.

Most optimization recommendations center on MSM management and creating more efficient delivery of care in a specified geographic environment.

Recommendations usually do not address strategic medical Command and Control (C2) or streamlining operational medical readiness and care delivery; somehow, these issues avoid the core this debate.

There have been (and continue to be) a number of models proposed to enhance the integration of military medical care.

Command Model. This is the Joint Task Force – Capital Medical (JTF CAPMED) model, in which organizations, resources, and personnel are aligned under a single commander. This model was first attempted in the late 1980s with the Joint Military Medical Command in San Antonio, Texas¹⁵. The idea was not sustained, not due to ineffectiveness of the idea but due to lack of force behind the commitment.

Non-command /Agreement-Driven Model. In this model, Service command structures remain in place and collaboration is achieved through joint business planning, memorandums of understanding, and various coordinating structures for ongoing management/oversight of the MHS “market area”¹⁶. Currently, there are a number of models along a spectrum of collaboration; examples include San Antonio (MOUs) to Landstuhl (MOUs and multi-Service staffing of medical facilities) to Tidewater/Norfolk and other military medical facilities such as the 121 General Hospital in Seoul, Korea, Tripler Army Medical Center in Hawaii, and the deployed hospital in support of Operation Enduring Freedom¹⁷. These MOUs though informal, serves the facilities well. They provide flexibility and good training opportunities for the providers. It also fosters

operating in a joint environment. Some of these agreements are long standing and have been inculcated in the normal business practice of these facilities.

Informal MSM Coordination. Military Treatment Facility (MTF) Commanders meet and share information on an ongoing basis, but there is no requirement to formally collaborate, no identification of a “market manager,” and no local oversight process to ensure inter-Service collaborative relationships are functioning in MSMs¹⁸.

Studies have been conducted and task forces established to specifically look at these MHS market areas for opportunities for better efficiency and consolidation¹⁹.

There is also constant exploration for opportunities to address questions such as:

- Does the “value” created by the MSMs outweigh the costs in creating, staffing, and sustaining an MSM offices?
- What are the attributes of an MSM and do they all look alike?
- What activities should a multi-service market manager be responsible for? Is it all capability areas or does it fluctuate?
- To whom is a multi-service manager accountable? What authorities should it have?
- What are the locations where MSMs need to be established?

In 2006, several options were examined with detailed Courses of Action (COA) analysis weighing three options. These options were compared using certain measures of effectiveness: Authority, interoperability, unique requirements, and operational

medicine²⁰. These COAs were compared for efficiency in the categories of duplication, mission delivery and costs.

- COA 1 is a Unified Medical Command responsible for C2 of medical structure.
- COA 2 is dual commands for C2, this COA allows multiple levels of capability area management.
- COA 3 is a single DoD medical service responsible to all services for healthcare delivery.

CLASSIFICATION (U)

Center for Naval Analysis Course of Action Evaluation Matrix

Course of Action	COA #1 Unified Command	COA #2 Dual Commands	COA #3 Single Service
Effectiveness			
Maintain clear lines of authority	+++	+	+++
Promote interoperable and interdependent processes, common standards and resource sharing	++	+	+++
Support joint and Service-unique requirements	+++	+	++
Balance the operational and benefit missions	+++	+/-	+++
Efficiency			
Eliminate layers of command and duplication	++	+/-	+++
Reduce cost of benefit mission delivery	++	+	+++
Potential annual cost savings¹	\$334M	\$271M	\$407M

¹- Uses figures from the "military, civilian and contractor" alternative. Figures from the "civilian and contractor" alternative would be \$306M, \$243M, and \$374M, respectively

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Figure 1. Center for Naval Analysis Course of Action Evaluation Matrix

The Center for Naval Analysis matrix indicates that a single service is the most effective and most efficient. Increased effectiveness and efficiency, not to mention savings, are strong arguments for a single medical service delivering healthcare to

military, families and retiree populations. A single health service or a Unified Medical Command would only be successful if service cultural ties to their own systems could be eliminated. Services will have to trust the consolidating services under a single command structure or lead agent service would provide responsive care when it is needed. The outcome of this comparison of COAs had a lot to do with the criteria considered. Though a single medical service may make sense, it may not be absolutely necessary. There are still requirements for services to support their operational forces and remain combat multipliers as they regenerate the force, this can be achieved in a command and control construct that allows a commander to tailor the medical support in both institutional and the operational environments as the mission dictates. This means that the most effective model would be a Unified Command. This model cannot affect the quality of care provided.

What Has Been Done So Far?

The medical education and training arena is an example of consolidation and transformation for many years. The longest standing joint medical technical training effort has been the Medical Maintenance Technicians course at the Fitzsimmons Army Medical Center Biomedical Equipment repair school in Colorado. It took a little longer for other joint training opportunities to be realized²¹.

The Ft. Sam Houston training center responsible for training all Army medical military occupational specialties—for both officers and enlisted—is now designated the Medical Education and Training Center (METC) of Excellence, a joint training base for all service medical departments' training programs²².

METC's creation was recognition that training people to execute core competency skills is universal even if there are idiosyncrasies in supporting sailors vs airmen vs soldiers. The basic concepts remain the same and there are equities to be gained. Laboratory technicians, X-Ray technicians, Operating Room technicians, along with other technical providers perform similar duties especially in the institutional medicine environment. Where there are differences, which remain the individual services' arguments to maintain their own training base, they exist in the operational medical environment. However, even in operational medical delivery, there are probably more similarities than differences.

Medical Logistics (MEDLOG) across the services has become far more joint in recent years. End to end management of the supply chain is the responsibility and interest of all three service medical departments who are users, executors and customers of the acquisition, distribution and maintenance of medical materiel²³. The changes in MEDLOG C2 have been notable in that the services have created a joint enterprise management process which provides a Council of Colonels approach to representing the services in making decision regarding delivering medical logistics to the joint force.

In addition to education and MEDLOG, another capability area that has become more joint in recent years is medical information systems architecture management. The Defense Health Information Management System (DHIMS) is now responsible to fund and monitor enterprise medical information technology²⁴. As with training and logistic, this capability shares many attributes that are common to users and customers across the services.

MTFs have operated in a rudimentary joint environment for many years by borrowing military manpower across the services, especially when it was deemed that the beneficiary population in a particular geographic region was more joint in nature. This was more prevalent in overseas bases in order to ease access challenges. There have also been efforts to combine medical services in large catchment areas to improve C2 and reduce redundant services in or eliminate redundant MTFs altogether. This was demonstrated in the formation of the JTF-CAPMED, designed as a 3-star level command controlling military medical activities in the National Capital Region²⁵.

Even with all the integration of efforts discussed above, the current MHS governance structure remains an amalgamation of collaborative agencies, joint capability areas, committees, standing agencies, and separate service management in most cases. There are still areas that have not been touched by any change in management processes. The business process largely continues as status quo.

Trends In Management of The Health Care Enterprise

The Department of Defense has been under steady pressure to reduce spending. The recent initiatives in Congress with the formation and failure “super committee” have specifically focused on the largest spenders of the nation’s budget²⁶. The Defense budget is at the top of discretionary spending in the national budget and one of the larger spending activities in the DoD budget is delivering health care to service members, retirees, and their families. The military has been asked to streamline business processes and find ways to cut costs over the next ten years in the Defense Health Program (DHP). In such a wide portfolio, fiscal management remains a challenge, especially with the mix of operational and institutional medicine. The tactics,

techniques and procedures of how we do business in the DHP must be reviewed for efficiencies. In many cases, operating more jointly will deliver those efficiencies.

There is a belief that self-initiated efficiencies, already implemented to create pseudo-joint capabilities, have been enough; and that any more consolidation might impair readiness. While an interesting perspective and a plausible conclusion, it requires more scrutiny and data validate. There is also strong contention that operating jointly is an inherent process improvement since it presents leverage that would otherwise be unavailable to service unique programs. The important thing is that any decision be based not on rhetoric but on data and solid process improvement measures.

MHS Governance has been discussed at the highest levels of DoD. The topic has been vetted at the highest levels of military leadership both in the services and in the joint arenas²⁷. The real challenge is gaining service acceptance of a governance construct that removes the DHP budget from the control of service chiefs. The idea of a “Joint Medical Command” has been an agenda item for the Operational Deputies on more than one occasion, but has been tabled for future discussion and research²⁸.

As noted, there are good examples of joint business processes that work well in the MHS, in medical logistics and supply chain management, information systems, and health education. Much has also been done in these capability areas at the operational levels in order to gain joint equity; however, there are several other capability portfolios that can become more joint to streamline the business processes. The greatest equities to be gained come from a top down approach that directs the enterprise into a joint environment; medical research and development comes to mind. The greatest and

most effective reform however, has to occur in command and control of medical departments. C2 is where the “money is to be made”.

Combining facilities, logistics acquisition, training and information system architecture seem to be more acceptable courses of action for the services. The fact is that these options allow the services to continue parochial business practices. There is nothing wrong with freedom of maneuver the services get from running their own healthcare delivery processes. There is also an element of trust that is missing in the services’ medical cultures. The services have to believe that the support will be there when they need it²⁹.

All these factors, initiatives and process changes have been positive steps in the right direction; however, they reinforce that true change comes in the form of command and control, not collaborative handshakes or initiatives that may not endure. The Defense Health System needs a Unified Medical Command.

Barriers to Joint C2

So, what are the challenges or barriers to a Unified Medical Command structure to oversee the delivery of health care to the joint force? Some barriers are obvious and some are not so obvious³⁰. The first challenge is proficiency; the services have been very adept at providing healthcare to their service beneficiaries and have done so very effectively. The services’ standard of excellence is hard to argue with and their constant emphasis on quality care, training providers and maintaining the best facilities is beyond question. So why try to fix something that works and works well?

Another barrier is service culture. Every service has a mission and that mission differs, if ever so slightly, from the other services³¹. It is the slight differences that cause

the separation anxiety that people feel about major organizational change. After more examination, the delivery of healthcare across the services is more similar than different. There are definitely similarities in the institutional healthcare. Examining processes in other areas such as MEDLOG reveals the same Prime Vendors executing the same contracts for medical materiel³². Similarities also exist in other areas to include research and development and physical examinations.

The services tend to focus most on the differences in the operational healthcare arena. As this is their *raison d'être*, they should. Still, operational medicine is very similar from service to service in that it must be self sustaining and functional in an austere environment. There are differences in deployable medical systems, but they tend to be in sustainment and not actual execution. The field medical equipment that comprises the major components of deployable systems tends to be the same or similar across the force³³.

There are two areas where this is not the case, delivering health care at sea and managing patients in the Air-Evac system. In both cases, there are service specific roles that are not replicated elsewhere and the services should retain executive agency over them. Otherwise patient care in a tactical environment ought to be far more standardized.

Opportunities

The question has been and continues to be how to find ways to do business that challenge normal business practices. The budgetary constraints that are about to affect DoD will have a direct effect on how DoD provides care to the beneficiary population. The environment will get more complicated as time goes on. Ten years of conflict in the

Middle East and in the global war on terrorism have left the US military with a complicated list of medical issues to deal with. Veterans face a wide range of health challenges, physical and psychological. These are long term and persistent issues and not easily fixed. There is a large cohort who will rely on the military health system for a long time. What further complicates the issue is that family members are also affected by their service-member's problems, particularly post-traumatic stress; they will also depend on the MHS.

There are cost / benefit issues associated with deferring patients to the Department of Veterans Affairs (DVA). In the long run, the costs are still a part of the overall cost of government health care, but they are not charged against DoD³⁴. The question is whether efficiencies can be gained by better integrating the two largest government institutional health systems. Should, for instance, the DVA take over institutional health care in its entirety; operating Military and DVA Medical Treatment Facilities and training physicians, nurses, medics and allied health specialists under a interdepartmental support agreement, while the military manages the operational health care systems?

This challenge is not peculiar to any one service and not even to the DVA who may well have a significant role in solving it. Since the services and DVA all have opportunities for gains, there should be a corporate solution. The only way to assure that solution is to approach it with joint (and interdepartmental) benefits in mind. Each service and the DVA are looking at viable solutions to holding down costs while maintaining quality of care.

As noted, the DHP consists of many aspects spanning the military healthcare continuum, from first responder care, through evacuation, to hospitalization and convalescence. Services include preventative medicine, treatment of acute and chronic illnesses, emergency care, convalescent care, and ancillary services. These areas are broad but they are common in their execution across the DHP. It is in this arena that “service unique” requirements are considered. In examining these capability areas there are apparent joint equities and opportunities for better business process that would result not just in cost savings but also increase in readiness.

Emergency Medicine: Good opportunity for developing joint capability since trauma remains constant and the way trauma is addressed will be the same no matter who is treating the injury. The basic tenants of emergency medicine are the same and the platforms by service are very similar. The Army uses Battalion Aide Stations that are equipped with Basic Life Support and Advanced Trauma Life Support capabilities, also known as BLS and ATLS, this platform is very similar to the Navy’s capability used to support Marines in the forward edge of the battle areas³⁵.

Preventative Medicine: All three services have substantial preventative medicine capabilities ranging from Epidemiology, Entomology, and Disease Prevention to insect control and food inspections. These capabilities are required for all services operational mission execution. Recent deployments to Haiti in support of post-earthquake disaster relief operations provided examples of how a joint medical task force brings together medical capabilities to execute a mission in a joint environment³⁶. Preventative Medicine (PM) was one of the most used capabilities in that environment. The PM community performed at high levels as a part of a joint medical task force. Army base

camps were serviced and sprayed by Air Force PM Personnel while the Army PM assets had similar and concurrent responsibilities in support of the service members deployed to that mission. The Navy Forward Deployable Preventive Medicine Unit, or FDPMU, was another asset with capabilities to execute the same missions. There are many opportunities in this capability area to gain efficiencies.

Surgery: The Army conducts operational surgery in two different arenas, one is the use of Forward Surgical Teams, or FSTs, and the other is in the Combat Support Hospital arena or CSH³⁷. The requirement to provide far forward surgery is necessary as a combat multiplier in order to sustain the force. This requirement is not peculiar to the Army, especially in a Joint environment. The function of field surgery is usually executed by proximity and not service unique. The FST capability also closely resembles the Air Force Emergency Medical System (EMEDS) and the Navy's deployable medical capability. This is another aspect of operational care that offers potential savings through more joint efforts and standardization.

Treatment: The commonalities in operation medicine treatment are boundless. The CSH is very similar to EMEDS and the Navy field hospitals³⁸. While each service has sustainability and logistics challenges, it would not be a great leap to morph a capability platform that could support all services and be sustained by all. This is one area that has the largest opportunities for savings and efficiencies since it is the area with the most equities. Theater evacuation standards determine how far forward we can hospitalize patients after injury. The recent wars in Iraq and Afghanistan have demonstrated that the nature of theater evacuation and hospitalization has changed drastically. The carnage and injuries now inflicted by modern weapons demands

immediate evacuation from Role I (first responder care) to Role IV(tertiary hospital care) capability much sooner than in even recent conflicts. Hospitalizing large numbers of troops in a theater of operation such as what was done in Korea and the 2nd World War will never be seen again³⁹. Sustaining treatment facilities in a modern battle space is both cost prohibitive and high risk. Weapons systems now have reach and accuracy that did not exist in the past and place areas once deemed as “safe” rear areas at risk. It is unlikely that we would deploy large medical treatment facilities to remain static and defenseless in future conflicts. The emphasis will be on robust evacuation and rightfully so. Such a shift presents an opportunity to adjust provider requirements numbers and seek further savings and efficiencies.

Evacuation: MEDEVAC platforms basically share the same requirements across the services⁴⁰. All services used ground vehicles, helicopters and fixed wing aircraft for strategic casualty evacuation (CASEVAC). Enroute care is standard and critical in-flight surgery, treatment and stabilization contributes to the very high survivability rates we now enjoy. The challenge is that the capabilities, training and professional requirements are all very similar and require the same capabilities in all services. Although the services may argue that their requirements are unique, closer examination would suggest that there are more similarities than differences. As previously discussed, there are opportunities here since we have now become evacuation heavy in combat operations and less focused on hospitalization in forward areas. A joint forcing function the assigns responsibilities to services based on capabilities would be very beneficial in this case. For instance, tactical CASEVAC would be the responsibility of the Army since the Army has the most forces at risk in this arena. Operational

Evacuation could be shared by the Navy and the Army. The Air Force would only participate in strategic evacuation.

Convalescence: There is no more place where opportunities to leverage equities exist like this capability area, simply because convalescence exists solely in the institutional medical environment. This addresses our largest facilities and the very crux of how the DoD provides healthcare to service members and their family members. This is no easy task since it is the foundation for the approximate \$57 Billion dollar enterprise annual budget⁴¹. The institutional medical capabilities have the most joint equity but may well be the most difficult in which to force joint operations. So far, initiatives like the JTF-CAPMED have attempted to accomplish just that. This initiative is ongoing and is still experiencing challenges almost four years after implementation. JTF-CAPMED was put together to exercise command and control of all the medical assets in the National Capital Region and surrounding areas. One of the challenges is consolidating the true statutory authorities to direct the business processes, not just exercise cursory control. Any subordination to a specific service Surgeon General will contradict the unity of command concept. It is unclear how this will work. Nor is it clear that the answer is a standing joint task force. The jury is still out and success is not guaranteed.

What Should Happen?

This paper advocates that the only acceptable solution is the development and implementation of a “Unified Medical Command”. This command structure would include a 3 Star General Officer/Flag Officer (GOFO) Commander, a 3 Star GOFO deputy commander for institutional medicine (different Service) and a 3 Star GOFO

deputy commander for operational medicine (different Service). This construct allows the services to maintain their 3 Star GO positions currently assigned to service Surgeons General. A 4 star GOFO would be optimal for many reasons but may be significantly difficult to implement. Creating a GOFO in the MHS would require a bill payer elsewhere. Each service already has 3 star GOFOs and would require no more "bill payers". The rest of the staff would consist of several 1 and 2 star GOFOs in operations, logistics, personnel, acquisition, and communications and so on. These billets aren't new, the bill payer would be GOFO slots already resident in the services and they would still maintain enough GOFO slots to deliver healthcare.

Once such a command is formed and given statutory authority, they can commence to assessing capability areas and develop ways to leverage equities. The difference with this process is that a Unified Medical Command can also implement programs and plans that are not hindered (as much) by parochialism. The difference in this initiative is that it is top down and not a bottom up approach which has proven ineffective. The military is a command and control organization and the culture responds to authority and there is no substitute. This process cannot be started by the services, this would require buy in and directive authority by the Secretariats, the Service Chiefs and the Joint Staff, not to mention the SECDEF. There would be tremendous push back by the medical departments and even by service chiefs. It is not a function of it not being the right thing to do but a matter of culture and trust. Each service will have to believe that their partners will stand and deliver when the time comes.

Conclusion

A Unified Medical Command would not be an easy proposition, nor will it be a quick one. The challenge is that in an age of sequestration and budget cuts, all have to be fiscally responsible. The best way to do this is to look for equities and leverage common capabilities in ways that benefit all. The armed services of the United States will always fight in joint environments. Any opportunity to increase interdependence to meet common needs is common sense.

If we are going to see change that is truly sustainable and is adhered to and not subjected to interference from parochial service structures, we must have a Joint Unified Medical Command. The concept of unity of command is tried and true in the military. Change can be “command directed” while still affording service input into the decision making processes through the design of the Unified Medical Command Staff. There are probably not too many areas as conducive to joint command and control in the military as healthcare delivery. This proposal will not solve the DoD budget issues, nor will it fix all the challenges in the military healthcare system; but there is no denying that there are opportunities to do business better. It is time to do away with collaborative efforts and start focusing on command directed solutions. C2 is clearly the military way of doing business and has always been effective. We should always look for opportunities to improve process, this one is clear; the DoD healthcare system deserves a Joint Unified Medical Command.

Endnotes

¹ Webster’s Dictionary, 2009 version: Definition and description of what is an “enterprise”

² WWW.navy.mil "article titled "Tri-care launches Multi-Service Markets in the NCR" September 2004... will serve to help link all the tri-service facilities, both big and little, in the national capital area together to form an integrated health delivery network under one health plan," said Beasley. "It will provide for more seamless care for the beneficiaries."

³ J4 JCS Brief (information brief) 2007: Contracted information paper. Multiservice markets explored as a possible opportunity to consolidate resources.

⁴ The MHS as a healthcare delivery system: medical capabilities in institutional and operational medicine. AMEDDC&S. Personal experience while working in the "Office of the Surgeon General" for two years.

ditional and operational medicine. AMEDDC&S. Personal experience while working in the "Office of the Surgeon General" for two years.

⁵ TRICARE History across DoD. Office of the Army Surgeon General. Description of "Tri-Care" Tricare business office. How does the MHS deliver Healthcare to the beneficiary population?

⁶ TRICARE History across DoD. Office of the Army Surgeon General. Description of "Tri-Care" Tricare business office. How does the MHS deliver Healthcare to the beneficiary population.

⁷ Personal experience with 20 years of military service: Service members traverse through the healthcare system in many facets and in many different venues I CONUS and OCONUS. PCS, TCS and TDY are constant for service members

⁸ USA MEDCOM management of medical unit deployments and individual augmentation deployment numbers of healthcare providers throughout OEF and OIF.

⁹ Military current retirement system: Service members can retire after 20 years of service with a few exceptions.

¹⁰ J4 JCS Tank Brief (Decision brief) Aug 2011: OPS DEP tank agenda item discussion reference Joint Medical C2

¹¹ AAA audit result that sites redundancies in the DoD healthcare system that can be changed to realize immediate cost savings. The audit led to the MHS chartering studies to look for opportunities for consolidation of services and capabilities.

¹² Title X, US Code: Services "Arm, Train and Equip" their own forces. Each Surgeon General is responsible for the delivery of Healthcare to their service. They must support the operational force, sustain readiness and take care of institutional medical requirements.

¹³ MHS Governance Information papers and briefings: Joint Staff Rand Study to examine the opportunity for a centralized MHS governance model.

¹⁴ “Case for a Purple Healthcare System” (study 2006) CNA: Results of an academic study on governance. Can another C2 structure create opportunities in the DHP to save money and streamline process.

¹⁵ JTF CAPMED implementation and information paper and briefings (Mar 2006) CNA: Comparative model on possible C2 processes in healthcare delivery. Which method is best utilized? May not have tested to most effective method of a Unified Medical Command.

¹⁶ “ How the Military Healthcare System may be reorganized” RAND Study 2001: A study on the potential re-organization of the MHS delivery C2 process.

¹⁷ MHS process of using MOUs, borrowed military manpower and mutual staffing agreements in order to provide training opportunities and augmentation for specific capabilities.

¹⁸ “ How the Military Healthcare System may be reorganized” RAND Study 2001

¹⁹ Joint Staff and Service HQs have commissioned many studies over time by RAND, LMI and other contractors to examine the MHS for equities.

²⁰ “How the Military Health System may be Reorganized” RAND Study 2001

²¹ BIOMEDICAL Technicians training program at Fitzsimmons Army Medical Center, Colorado. The BEMETS training school at Fitzsimmons is a center of excellence for medical equipment repair for all the services.

²² Medical Education and Training Information papers, Ft Sam Houston, TX: The METC was established as a center of excellence to train medical technicians in all services. Training has been occurring for years, the METC formalized the agreement.

²³ “Joint Medical Logistics Governance” Process. DMSB and JMLC governance directive: Integrated Medical logistics Management group and Joint MEDLOG Center at Ft. Detrick, MD management processes.

²⁴ “J4 JCS Tank Brief” (Decision Brief) Aug 11: OPS DEP tank agenda item discussion reference joint medical command C2: Tabled for further discussion and development.

²⁵ “Ibid”

²⁶ Congressional “Super Committee” results 2011; US Budget deficit reduction process. 2011. Federal Government attempt to reduce the deficit and balance the budget. Requirements for DoD to reduce spending and cut force structure over the next ten years.

²⁷ “Ibid”

²⁸ Joint Staff Joint Medical Command brief to the OPS DEP Tank 2011: OPS DEP tank agenda item discussion reference joint medical command C2: Tabled for further discussion and development

²⁹ Personal experience of working for three years on the joint Staff: 2005-2009, served on several joint governance boards such as the DMLC and advisor to the Defense Medical Standardization Board.

³⁰ Personal experience on MACOM level staffs working joint equity issues: Worked at the United States Army Medical Materiel Agency, TWI at LMI, Army OTSG and the Joint Staff.

³¹ Services healthcare mission and service to their beneficiaries per HQ MACOM staffs: Surgeons Generals of the services MHS management of healthcare delivery.

³² Service medical logistics processes in medical facilities, R&D command and physical exams processes: Acquisition, distribution and medical materiel contracting in healthcare facilities.

³³ Military Deployable Medical Systems acquisition and maintenance programs. Joint medical logistics command at Ft. Detrick, MD. Operational medical care delivery platforms for each service.

³⁴ Department of Veteran's Affairs operations and missions: The DVA cooperates with DoD to deliver continued healthcare to service members: VA operates the nation's largest integrated health care system with more than 1,400 sites of care, including hospitals, community clinics, community living centers, domiciliary, readjustment counseling centers, and various other facilities. For additional information on VA health care, visit www.va.gov/health.

³⁵ Service Medical Doctrine for healthcare delivery across the operational force: Medical Center and Schools and centers of excellence for each service. Healthcare delivery doctrine across the joint force.

³⁶ Deployment to support Haiti Earthquake recovery 2010, 56TH Multifunctional Medical Battalion: Commanded "Task Force Medical" in support of HADR post earthquake.

³⁷ Army Forward Surgical Team doctrine; AMEDDC&S, FST deployment and employment. Forward surgery doctrine in the operational environment.

³⁸ Service Medical Doctrine for healthcare delivery across the operational force: each service has medical care doctrine that is documented in their service manuals.

³⁹ OIF and OEF Theatre evacuation policy processes, casualty evacuation numbers and times. Traditional evacuation of casualties has been immediately after stabilization. Hospitalization in the AOR was not the emphasis.

⁴⁰ Service Medical Doctrine for healthcare delivery across the operational force: Medical Center and Schools and centers of excellence for each service. Healthcare delivery doctrine across the joint force.

⁴¹ Defense Health Program budget for 2011; DHP allocation and execution authority: Health Affairs and Surgeons Generals execution of their budget processes.